AUTHORIZATION FOR RELEASE OF INFORMATION

TO: Any Physician, Hospital, Clinic, School, Therapist or Agency

Other:_____

REGARDING: _____
(Name of child or adult)

By signing this form, authority is given to:

☐ California Department of Social Services, Adoptions Branch

☐ Other:_____

To receive any information in your files concerning the undersigned and (if applicable) the above-name child, including:

☐ Medical information and history

☐ Psycho-Social information and history

☐ Test or examination results

☐ Other information: _____

The information requested is necessary in an adoption homestudy being done by the above agency. Nonidentifying information received concerning birth parents or prospective adoptive child(ren) will be shared with the adoptive parent(s) prior to finalization of the adoption. Identifying information will not be disclosed unless permitted by law.

This authorization is in effect for 12 months from the date signed below.

Signature of Person(s) Authorizing Release of Information _____

_____

Date: _____

Relationship of person(s) authorizing release of information: _____